

Professional Application



First / Middle / Last Name

SS#

DOB

PHYSICAL EXAM

*****TO BE COMPLETED BY PHYSICIAN*****

Name _____
(Print First, Middle and Last Name)

Date of Physical Exam _____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to perform the functions of the position without restrictions.

Physician Signature _____

Physician Name _____
(Please Print)

License Number _____

Address _____

City _____ State _____ Zip _____

Phone _____

Fax _____

TB / PPD FORM

Proof of TB immunization must be submitted annually.

Name _____
(Print First, Middle and Last Name)

Manufacturer: _____

Lot # _____

Expiration Date: _____

TEST PLACED _____ Left Arm _____ Right Arm

By _____ Date _____

TEST READ (48 – 72 Hours Later)

By _____ Date _____ Result: _____ / _____ mm

CHEST X-RAY _____ Positive _____ Negative Date _____

**Please attach proof of Chest X-Ray